

NEW HAMPSHIRE Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 1. Instructions for preparing your advance directive, please read all the instructions.
 2. Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your New Hampshire Advance Directive

This packet contains a legal document, a **New Hampshire Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part I is the **New Hampshire Power of Attorney for Health Care**. This part lets you name someone, called your agent, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part I also allows you to express your desires regarding your health care and other advance planning decisions, including your desires regarding life-sustaining treatments, in order to help guide your agent.

Part I goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part II is a **New Hampshire Declaration**, which is your state's living will. The declaration in Part II is limited to a statement that you want life-sustaining treatment withheld or withdrawn if you are near death or permanently unconscious. If this is not your choice, you should not complete Part II. In addition, because Part II is limited in this way and Part I allows you to express a broader range of choices, if you plan to complete Part I, you may wish to leave Part II blank and record your advance planning wishes in Part I only.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is an **Organ Donation Form**.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions for Completing Your New Hampshire Advance Directive

How do I make my Advance Directive legal?

In order to make your Advance Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses. Neither of your witnesses can be:
 - your agent,
 - your spouse,
 - your heir or any person entitled to any part of your estate, or
 - your attending physician or Advanced Registered Nurse Practitioner (ARNP), or any person acting under the direction and control of your attending physician or ARNP.

In addition, one of your witnesses **cannot** be:

- your health or residential care provider, or
- an employee of your health or residential care provider

OR

2. Sign your document in the presence of a notary public or justice of the peace.

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You can revoke your advance directive by:

1. A written revocation delivered to your agent or to your health care provider or residential care provider that expresses your intent to revoke your advance directive and that is signed and dated by you.
2. Orally revoking your advance directive in the presence of two or more witnesses, none of whom is your spouse or heir.
3. Any other act evidencing your intent to revoke the advance directive, such as burning, tearing, or obliterating the advance directive, or directing somebody else to destroy the document in your presence.
4. Executing a new advance directive.

If you named your spouse as your agent, filing an action for divorce, legal separation, annulment, or legal separation will automatically revoke your spouse's authority as agent, unless you specify otherwise in the "additional instructions" section on page 11 of your form.

**INFORMATION CONCERNING THE DURABLE POWER OF
ATTORNEY FOR HEALTH CARE (PART I)**

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise in the directive, this directive gives the person you name as your health care agent the power to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself. "Health care " means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent, refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment.

Your health care agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or treatment you want to be sure you receive. Your health care agent's power will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not want to be treated by a doctor or examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach additional pages to the document if you need more space to complete your statement.

If you want to give your health care agent power to withhold or withdraw medically administered nutrition and hydration, you must say so in your directive. Otherwise, your health care agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

DISCLOSURE
STATEMENT

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NEW HAMPSHIRE ADVANCE DIRECTIVE — PAGE 2 OF 11

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition and prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have had, if those decisions by your health care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions which may be made for you by your health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, advanced registered nurse practitioner, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced registered nurse practitioner and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

DISCLOSURE
STATEMENT
(CONTINUED)

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EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.

YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO ARNP'S IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

- The person you have designated as your health care agent;
- Your spouse or heir at law;
- Your attending physician or ARNP, or person acting under the direction or control of the attending physician or ARNP;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

DISCLOSURE
STATEMENT
(CONTINUED)

**PART I: NEW HAMPSHIRE DURABLE POWER OF ATTORNEY
FOR HEALTH CARE**

PRINT YOUR NAME

I, _____,
(name)

PRINT THE NAME
AND ADDRESS OF
YOUR AGENT

hereby appoint _____
(name of agent)

of _____
(address)

In the event the person I appoint above is unable, unwilling or unavailable,
or ineligible to act as my health care agent, I hereby appoint

PRINT THE NAME
AND ADDRESS OF
YOUR ALTERNATE
AGENT

(name of an alternate agent)

of _____
(address)

_____ as alternate agent.

When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this advance directive, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health-care agent should make decisions for me that my health-care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

NEW HAMPSHIRE ADVANCE DIRECTIVE — PAGE 5 OF 11

**STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS
REGARDING HEALTH CARE DECISIONS.**

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT.

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

____(a) life-sustaining treatment not be started, or if started, be discontinued.

OR

____(b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

____(a) life-sustaining treatment not be started, or if started, be discontinued.

OR

____(b) life-sustaining treatment continue to be given to me.

B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION.

1. I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued.

OR

____(b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

INSTRUCTION
STATEMENTS

INITIAL THE
RESPONSES THAT
REFLECT YOUR
WISHES

INITIAL ONLY ONE
CHOICE

INITIAL ONLY ONE
CHOICE

INITIAL ONLY ONE
CHOICE

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

LOCATION OF THE ORIGINAL AND COPIES

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C. ADDITIONAL INSTRUCTIONS.

Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave this question blank if you desire.

(attach additional pages as necessary)

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

The original of this document will be kept at: _____, and the following persons and institutions will have signed copies:

Name

Address

Name

Address

PRINT THE DATE

PRINT YOUR NAME

PART II. NEW HAMPSHIRE DECLARATION

Declaration made this _____ day of _____.
(day) (month, year)

I, _____,
(name)

being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease or illness and I am certified to be near death or in a permanently unconscious condition by 2 physicians or a physician and an ARNP, and two physicians or a physician and an ARNP have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating or drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

(Initial beside your choice of (a) or (b).)

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued,

OR

____(b) even if other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

INITIAL ONLY ONE CHOICE

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ADD ADDITIONAL INSTRUCTIONS, IF ANY

NOTE: PART II IS ONLY EFFECTIVE TO STATE A DECISION TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENTS IF YOU ARE NEAR DEATH OR PERMENANTLY UNCONSCIOUS.

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

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Other directions:

Multiple horizontal lines for writing additional directions.

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full meaning and significance of this declaration, and I am emotionally and mentally competent to make this declaration.

PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

Alternative No. 1: Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Neither of your witnesses **can be**:

- your agent,
- your spouse,
- your heir or any person entitled to any part of your estate either under your last will and testament or by operation of law,
- your attending physician or ARNP, or person acting under the direction and control of your attending physician or ARNP.

In addition, one of your witnesses **cannot** be:

- your health or residential care provider, or an employee of your health or residential care provider

OR

Alternative No. 2: Witnessed by a notary public or justice of the peace

IF YOU DECIDE TO
HAVE YOUR
ADVANCED
DIRECTIVE
WITNESSED, USE
ALTERNATIVE NO.
1, BELOW (P. 15)

IF YOU DECIDE TO
HAVE YOUR
ADVANCE
DIRECTIVE
NOTARIZED, USE
ALTERNATIVE NO.
2, BELOW (P. 16)

Alternative No. 1: Sign before witnesses.

I sign my name to this Advance Directive on _____ at _____, _____.
(date) (city) (state)

(signature)

(print name)

WITNESS ATTESTATION

We declare that the principal appears to be of sound mind and free from duress at the time this advance directive is signed and that the principal affirms that he or she is aware of the nature of the advance directive and is signing it freely and voluntarily.

Witness 1:

Signature: _____ Date _____

Print Name: _____

Residence Address: _____

Witness 2:

Signature: _____ Date _____

Print Name: _____

Residence Address: _____

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Alternative No. 2: Sign before a notary public or justice of the peace.

I sign my name to this Advance Directive on

_____ at _____, _____.
(date) (city) (state)

(signature)

(print name)

SIGN AND PRINT
YOUR NAME, THE
DATE, AND
LOCATION HERE

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC OR JUSTICE OF THE PEACE

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing advance directive was acknowledged before me this ____ day of _____, 20____, by _____ (the "Principal").

Notary Public/Justice of the Peace

My Commission Expires: _____

A NOTARY PUBLIC OR JUSTICE OF THE PEACE MUST COMPLETE THIS SECTION

NEW HAMPSHIRE ORGAN DONATION FORM – PAGE 1 OF 1

ORGAN DONATION
(OPTIONAL)

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

ADD NAME OR
INSTITUTION (IF
ANY)

PRINT YOUR NAME,
SIGN, AND DATE
THE DOCUMENT

YOUR WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under New Hampshire law.

I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _____

Pursuant to New Hampshire law, I hereby give, effective on my death:

Any needed organ or parts.

The following part or organs listed below:

For (initial one):

Any legally authorized purpose.

Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in our presence. We signed this document as witnesses in the declarant's presence and in each other's presence.

Witness _____ Date _____

Address _____

Witness _____ Date _____

Address _____

Courtesy of Caring Connections
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You Have Filled Out Your Health Care Directive, Now What?

1. Your New Hampshire Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your New Hampshire document.
7. Be aware that your New Hampshire document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**